OMB#: 0935-0098

PATIENT ID: _____

PROVIDER ID: _____

PROVIDER NAME: _____

|__|__|__|
OFFICE
USE ONLY

FORM _____ OF _____

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER SURVEY

HOSPITAL EVENT FORM

REFERENCE YEAR 1997

HOSPITAL EVENT FORM

[COMPLETE ONE FORM FOR EACH EVENT]

QUESTIONS 1 THROUGH 4: TO BE COMPLETED WITH MEDICAL RECORDS.

READ ONLY FOR FIRST EVENT FOR THIS PATIENT: (PATIENT NAME) reported that (he/she) received health care services from this facility during 1997.

MEDICAL RECORDS

1. The (first/next) time (PATIENT NAME) received services during calendar year 1997, were the services received: [CODE ONLY ONE]

As an Inpatient; 1 (Q2a)
In a Hospital Outpatient Department; 2 (Q2c)
In a Hospital Emergency Room; or 3 (Q2c)
Somewhere else? (SPECIFY:) _____ 4 (Q2c)
LONG TERM CARE UNIT (SNF, etc.) (SPECIFY:) _____ 5 (Q2a)

Inpatient,
Outpatient,
Emergency Room,
Somewhere else,
Long Term Care

Somewhere else Specify, Text

Long Term Care Unit Specify, Text

2a. What were the admit and discharge dates of the (inpatient stay/stay)?

	MO	DAY	YR
ADMIT:	_____	_____	19____
DISCHARGE:	_____	_____	19____

Admit Date

Discharge Date

2b. Was (PATIENT NAME) admitted from the emergency room?

YES ..... 1 (COMPLETE SEPARATE EVENT FORM FOR ER EVENT)
NO 2

GO TO Q3

Yes, No

2c. What was the date of this visit?

MO	DAY	YR
_____	_____	19____

Visit Date

3. Please give me the name, specialty and telephone number of each physician who provided services during the (TYPE OF EVENT) on (DATE(S)) and whose charges might not be included in the hospital bill. We want to include such doctors as radiologists, anesthesiologists, pathologists, and consulting specialists, but not residents, interns, or other doctors in training whose charges are included in the hospital bill.

Separately Billing Doctors,
No Separately Billing Doctors

[RECORD NAMES ON SEPARATELY BILLING DOCTOR FORM. IF RESPONDENT IS NOT SURE WHETHER A PARTICULAR DOCTOR'S CHARGES ARE INCLUDED IN THE HOSPITAL BILL, RECORD INFORMATION FOR THAT DOCTOR ON SEPARATELY BILLING DOCTOR FORM.]

SEPARATELY BILLING DOCTORS FOR THIS EVENT 1
NO SEPARATELY BILLING DOCTORS FOR THIS EVENT 2

4a. I need the diagnoses for (this stay/this visit). I would prefer the ICD-9 codes (or DSM-IV codes), if they are available. [IF CODES ARE NOT USED, RECORD DESCRIPTIONS.]

Check box
Condition Code Number
Condition Description, Text

|__| _____ |__|__| OFFICE USE ONLY
|__| _____
|__| _____ |__|__| OFFICE USE ONLY
|__| _____

4b. Which of these was the principal diagnosis?

Principal Diagnosis

IF ONLY ONE DIAGNOSIS, GO TO Q4c.
IF MORE THAN ONE DIAGNOSIS:
- CHECK BOX FOR PRINCIPAL DIAGNOSIS
- CIRCLE '-8' IF PRINCIPAL DIAGNOSIS NOT KNOWN..... -8

4c. Have we covered all of this patient's events during the calendar year 1997?

Yes, all events covered,
No, need to cover additional events

YES, ALL EVENTS COVERED 1 (Q4d)
NO, NEED TO COVER ADDITIONAL EVENTS..... 2 (Q1-NEXT EVENT FORM)

4d. IF ALL EVENTS ARE RECORDED FOR THIS PATIENT, REVIEW NUMBER OF EVENTS REPORTED BY HOUSEHOLD.

No Difference or more events reported,
Fewer events reported

Explanation of Discrepancy, Text

NO DIFFERENCE OR FACILITY REPORTED MORE EVENTS THAN HOUSEHOLD ..... 1 (ENDING FOR MEDICAL RECORDS)

FACILITY RECORDED FEWER VISITS..... 2
PROBE: (PATIENT NAME) reported (NUMBER) events at (FACILITY) during 1997, but I have only recorded (NUMBER) visits. Do you have any information in your records that would explain this?

_____

_____

GO TO ENDING FOR MEDICAL RECORDS

ENDING FOR MEDICAL RECORDS:
GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END. THEN ATTEMPT CONTACT WITH PATIENT ACCOUNTS OR ADMINISTRATIVE OFFICE.

QUESTIONS 5a THROUGH END: TO BE COMPLETED WITH PATIENT ACCOUNTS.

READ ONLY FOR FIRST EVENT FOR THIS PATIENT: I have information from Medical Records that (PATIENT NAME) received health care services on [READ DATES OF ALL VISITS AND INPATIENT STAYS].

I'd like to ask you about the (visit on/stay which began on) [FIRST/NEXT DATE].

BOX 1
IF EVENT IS AN OUTPATIENT VISIT OR EMERGENCY ROOM VISIT OR SOMEWHERE ELSE (SEE Q1), CONTINUE WITH Q5a. IF EVENT IS AN INPATIENT STAY OR LONG TERM CARE UNIT (SEE Q1), GO TO Q 14.

GLOBAL FEE

5a. Was the visit on that date covered by a **global fee**, that is, was it included in a charge that covered services received on other dates as well?
[IF NECESSARY: *An example would be a patient who received a series of treatments, such as chemotherapy, that was covered by a single charge.*]

Yes, No

YES..... 1
NO..... 2 (Q6a)

5b. Did the global fee for this date cover any services received while the patient was an inpatient?

Yes, No

YES..... 1
NO..... 2 (Q5d)

5c. What were the admit and discharge dates of that stay?

Admit Date

Discharge Date

MO DAY YR
ADMIT: _____/_____/_____
DISCHARGE: _____/_____/_____

5d. What were the other dates on which services covered by this global fee were provided? Please include dates before or after 1997 if they were included in the global fee.

Other Dates included in the Global Fee

MO DAY YR	MO DAY YR	
____/____ 19 ___	____/____ 19 ___	|__|__|
____/____ 19 ___	____/____ 19 ___	OFFICE
____/____ 19 ___	____/____ 19 ___	USE ONLY
____/____ 19 ___	____/____ 19 ___	
____/____ 19 ___	____/____ 19 ___	
____/____ 19 ___	____/____ 19 ___	|__|__|
____/____ 19 ___	____/____ 19 ___	OFFICE
____/____ 19 ___	____/____ 19 ___	USE ONLY

5e. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee?

YES..... 1
NO..... 2

Yes, No

6a. I need to know what services were provided during (this visit/these visits). I would prefer the CPT-4 codes, if they are available.
[IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.]

6b. ASK FOR EACH CPT-4 CODE OR DESCRIPTION: What was the **full established charge** for this service, before any adjustments or discounts?
[EXPLAIN IF NECESSARY: *The **full established charge** is the charge maintained in the hospital's master fee schedule for billing insurance carriers and Medicare or Medicaid. It is the "list price" for the service, before consideration of any discounts or adjustments resulting from contractual arrangements or agreements with insurance plans.*]
[IF NO CHARGE: *Some facilities that don't charge for each individual service do associate dollar amounts with services in their records for purposes of budgeting or cost analysis. This kind of information is sometimes called a "**charge equivalent**." Could you give me the charge equivalents for these procedures*?]

CPT-4 Code Number
Description of Services, Text
Full Established Charge

CPT-4 (including modifier)	Full established charge at time of visit or charge equivalent	|__|__| OFFICE USE ONLY
a. _____	$_____.____	
b. _____	$_____.____	
c. _____	$_____.____	
d. _____	$_____.____	
e. _____	$_____.____	|__|__| OFFICE USE ONLY
f. _____	$_____.____	
g. _____	$_____.____	
h. _____	$_____.____	
i. _____	$_____.____	
j. _____	$_____.____	
k. _____	$_____.____	

7. IF NOT VOLUNTEERED, ASK: And what was the total? [IF NOT AVAILABLE, COMPUTE.]

Total Charges

TOTAL CHARGES **$_____.___**

8. Was the facility reimbursed for (this visit/these visits) on a fee-for-service basis or capitated basis?
[EXPLAIN IF NECESSARY:]
***Fee-for-service** means that the facility was reimbursed on the basis of the services provided*.
***Capitated basis** means that the patient was enrolled in a prepaid managed care plan where reimbursement is not tied to specific visits.*
[INTERVIEWER: IF IN DOUBT, CODE FEE-FOR-SERVICE.]

Fee-for-Service Basis,
Capitated Basis

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS..... 2 (Q12a)

9. From what sources has the facility received payment for (this visit/these visits) and how much was paid by each source?
IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?
INTERVIEWER: IF RESPONSE IS THE PATIENT PAYS A MONTHLY PREMIUM, GO BACK TO Q8 AND CHANGE CODE TO 2 (CAPITATED BASIS).

a. Patient or patient's family $_____.____
b. Medicare $_____.____
c. Medicaid $_____.____
d. Private Insurance $_____.____
e. VA $_____.____
f. CHAMPVA/CHAMPUS $_____.____
g. OTHER (SPECIFY:) _____ $_____.____

Patient or Family Payment
Medicare Payment
Medicaid Payment
Private Insurance Payment
VA Payment
CHAMPVA/CHAMPUS Payment
Other Source Payment
Other Source Specify, Text

10. IF NOT VOLUNTEERED, ASK: And what was the total? [IF NOT AVAILABLE, COMPUTE.]

TOTAL PAYMENTS **$_____.__**

Total Payments

BOX 2
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?
YES ..... 1 (BOX 3)
NO 2 (Q11)

Box 2

11. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

Adjustment or discount
Medicare or Medicaid
Contractual arrangement
Courtesy discount
Insurance write-off
Other
Other Specify, Text
Expecting additional payment
Patient or Family
Medicare
Medicaid
Private Insurance
VA
CHAMPVA/CHAMPUS
Other
Other Specify, Text
Charity care or sliding scale
Bad debt
Payments more than charges
Medicare or Medicaid
Other
Other Specify, Text

PAYMENTS LESS THAN CHARGES:	YES	NO
Adjustment or discount		
Medicare or Medicaid limit or adjustment	1	2
Contractual arrangement with insurer or managed care organization	1	2
Courtesy discount	1	2
Insurance write-off	1	2
Other (Specify:)_____	1	2
Expecting additional payment		
Patient or Patient's Family	1	2
Medicare	1	2
Medicaid	1	2
Private Insurance	1	2
VA	1	2
CHAMPVA/CHAMPUS	1	2
Other (Specify:)_____	1	2
Charity care or sliding scale	1	2
Bad debt	1	2
PAYMENTS MORE THAN CHARGES:		
Medicare or Medicaid Adjustment	1	2
Other (Specify:)	1	2

_____

GO TO BOX 3

CAPITATED BASIS

12a. What kind of insurance plan covered the patient for (this visit/these visits)? Was it:
[CODE ALL THAT APPLY]
IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Medicare
Medicaid
Private Insurance
Something else
Something else Specify
VA/CHAMPVA/CHAMPUS
Don't Know
No Insurance/None

Medicare; 1
Medicaid; 2
Private Insurance; or..... 3
Something else? (SPECIFY:) 4
_____
VA/CHAMPVA/CHAMPUS 5
DON'T KNOW..... 8
NO INSURANCE/NONE..... 9

12b. Was there a co-payment for (this visit/these visits)?

Yes, No

YES..... 1
NO..... 2 (Q12e)

12c. How much was the co-payment?

Co-payment amount

$_____.__

12d. Who paid the co-payment?
[CODE ALL THAT APPLY]
IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Patient or Family
Medicare
Medicaid
Private Insurance
Other
Other Specify, Text
Don't Know

PATIENT OR PATIENT'S FAMILY..... 1
MEDICARE 2
MEDICAID 3
PRIVATE INSURANCE 4
OTHER
(SPECIFY:) _____ 5
DON'T KNOW..... 8

12e. Do your records show any other payments for (this visit/these visits)?

Yes, No

YES 1
NO ..... 2 (BOX 3)

12f. From what other sources has the facility received payment for (this visit/these visits) and how much was paid by each source?
IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Patient or Family
Medicare
Medicaid
Private Insurance
VA
CHAMPVA/CHAMPUS
Other
Other Specify, Text

a. Patient or patient's family	$__________.____
b. Medicare	$__________.____
c. Medicaid	$__________.____
d. Private Insurance	$__________.____
e. VA	$__________.____
f. CHAMPVA/CHAMPUS	$__________.____
g. OTHER (SPECIFY:) ______________________	$__________.____

BOX 3
GLOBAL FEE SITUATION (Q5a=YES) 1 (Q23)
RECORDED 5 OR FEWER EVENTS 2 (Q23)
RECORDED 6 OR MORE EVENTS 3 (Q13a)

BOX 3

REPEATING IDENTICAL VISITS

13a. Were there any other visits for this patient during 1997 for which the services and charges were identical to the services and charges for the visit on (DATE OF THIS EVENT)?
[EXPLAIN, IF NECESSARY: *We are referring here to **repeating identical visits**. These usually occur when the patient has a condition that requires very frequent visits, such as once- or twice-a-week physical therapy.*]

Yes, No

YES 1
NO 2 (Q23)

13b. During 1997 how many other visits were there for which the services and charges were identical to the (DATE OF THIS EVENT)?

Number of Identical Visits

OF VISITS_____________

|__|__|__|
OFFICE USE ONLY

13c. Please tell me the dates of those other visits.
[IF THERE WERE MORE THAN 30 IDENTICAL VISITS, ENTER THE DATES FOR THE FIRST 30.]

Other Identical Visit Dates

MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
___/___ 19__	___/___ 19 __	___/___ 19 __
___/___ 19__	___/___ 19 __	___/___ 19 __
___/___ 19__	___/___ 19 __	___/___ 19 __
___/___ 19__	___/___ 19 __	___/___ 19 __
___/___ 19__	___/___ 19 __	___/___ 19 __
___/___ 19__	___/___ 19 __	___/___ 19 __
___/___ 19__	___/___ 19 __	___/___ 19 __
___/___ 19__	___/___ 19 __	___/___ 19 __
___/___ 19__	___/___ 19 __	___/___ 19 __
___/___ 19__	___/___ 19 __	___/___ 19 __
___/___ 19__	___/___ 19 __	___/___ 19 __

|__|__|__|
OFFICE USE ONLY

GO TO Q23

PATIENT ACCOUNTS QUESTIONS FOR INPATIENT.

14. According to Medical Records, (PATIENT NAME) was an inpatient during the period from [DATE] to [DATE]. What was the DRG for this stay?

DRG
DRG not Recorded

DRG: _____ (BOX 4)

DRG NOT RECORDED 1 (Q15)

15. Did the patient have any surgical procedure during this stay?

Yes, No

YES..... 1
NO ..... 2 (BOX 4)

16a. What surgical procedures were performed during this visit? Please give me the procedure codes, that is the CPT-4 codes, if they are available. [IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.]

Check box
CPT-4 Code Number
Surgical Description
Procedure Description

|__| _____ |__|__| OFFICE USE ONLY
|__| _____
|__| _____ |__|__| OFFICE USE ONLY
|__| _____

16b. Which of these was the principal surgical procedure?

Principal Surgical Procedure

IF ONLY ONE PROCEDURE, GO TO BOX 4.
IF MORE THAN ONE PROCEDURE:
- CHECK BOX FOR PRINCIPAL PROCEDURE
- CIRCLE '-8' IF PRINCIPAL PROCEDURE NOT KNOWN .....-8

BOX 4
ADMITTED FROM EMERGENCY ROOM
(Q2b=YES) 1 (Q17a)
OTHERWISE 2 (Q17b)

BOX4

17a. What was the **full established charge** for this inpatient stay, before any adjustments or discounts? Please do not include any emergency room charges.

FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:

$_____ . _____

17b. What was the **full established charge** for this inpatient stay, before any adjustments or discounts?
[EXPLAIN IF NECESSARY: *The **full established charge** is the charge maintained in the hospital's master fee schedule for billing insurance carriers and Medicare or Medicaid. It is the "list price" for the service, before consideration of any discounts or adjustments resulting from contractual arrangements or agreements with insurance plans.*]
[IF NO CHARGE: *Some facilities that don't charge for each individual service do associate dollar amounts with services in their records for purposes of budgeting or cost analysis. This kind of information is sometimes called a "**charge equivalent**." Could you give me the charge equivalent for this inpatient stay?*]

Full Established Charge

Emergency Room included,
Emergency Room not included

EMERGENCY ROOM CHARGE INCLUDED 1
EMERGENCY ROOM CHARGE NOT INCLUDED OR NOT APPLICABLE 2

18. Was the facility reimbursed for this inpatient stay on a fee-for-service basis or capitated basis?
[EXPLAIN IF NECESSARY:]
***Fee-for-service** means that the practice was reimbursed on the basis of the services provided*.
***Capitated basis** means that the patient was enrolled in a prepaid managed care plan where reimbursement is not tied to specific visits*.
[INTERVIEWER: IF IN DOUBT, CODE FEE-FOR-SERVICE.

Fee-for-Service Basis,
Capitated Basis

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS 2 (Q22a)

19. From what sources has the facility received payment for this stay and how much was paid by each source?
IF NAME OF INSURER, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Patient or Family
Medicare
Medicaid
Private Insurance
VA
CHAMPVA/CHAMPUS
Other
Other Specify, Text

a. Patient or patient's family $_____.____
b. Medicare $_____.____
c. Medicaid $_____.____
d. Private Insurance $_____.____
e. VA $_____.____
f. CHAMPVA/CHAMPUS $_____.____
g. OTHER (SPECIFY:) $_____.____
_____

20. IF NOT VOLUNTEERED, ASK: And what was the total?
[IF NOT AVAILABLE, COMPUTE.]

TOTAL PAYMENTS **$_____.__**

Total Payments

BOX 5
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?
YES 1 (Q23)
NO 2 (Q21)

BOX 5

21. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

Adjustment or discount
Medicare or Medicaid
Contractual arrangement
Courtesy discount
Insurance write-off
Other
Other Specify, Text
Expecting additional payment
Patient or Family
Medicare
Medicaid
Private Insurance
VA
CHAMPVA/CHAMPUS
Other
Other Specify, Text
Charity care or sliding scale
Bad debt
Payments more than charges
Medicare or Medicaid
Other
Other Specify, Text

PAYMENTS LESS THAN CHARGES:	YES	NO
Adjustment or discount		
Medicare or Medicaid limit or adjustment	1	2
Contractual arrangement with insurer or managed care organization	1	2
Courtesy discount	1	2
Insurance write-off	1	2
Other (Specify:)_____	1	2
Expecting additional payment		
Patient or Patient's Family	1	2
Medicare	1	2
Medicaid	1	2
Private Insurance	1	2
VA	1	2
CHAMPVA/CHAMPUS	1	2
Other (Specify:)_____ _____	1	2
Charity care or sliding scale	1	2
Bad debt	1	2
PAYMENTS MORE THAN CHARGES:		
Medicare or Medicaid Adjustment	1	2
Other (Specify:)	1	2

_____

GO TO Q23

CAPITATED BASIS

22a. What kind of insurance plan covered the patient for (this visit/these visits)? Was it:
[CODE ALL THAT APPLY]
IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Medicare
Medicaid
Private Insurance
Something else
Something else Specify, Text
VA/CHAMPVA/CHAMPUS
Don't Know
No insurance/None

Medicare;	1
Medicaid;	2
Private Insurance; or	3
Something else? (SPECIFY:)	4
_____	
VA/CHAMPVA/CHAMPUS	5
DON'T KNOW	8
NO INSURANCE/NONE	9

22b. Was there a co-payment for (this visit/these visits)?

Yes, No

YES	1	
NO	2	(Q22e)

22c. How much was the co-payment?

Co-payment amount

$_____.__

22d. Who paid the co-payment?
[CODE ALL THAT APPLY]
IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Patient or Family
Medicare
Medicaid
Private Insurance
Other
Other Specify, Text
Don't Know

PATIENT OR PATIENT'S FAMILY..... 1
MEDICARE 2
MEDICAID 3
PRIVATE INSURANCE 4
OTHER
(SPECIFY:) _____ 5
DON'T KNOW..... 8

22e. Do your records show any other payments for (this visit/these visits)?

Yes, No

YES 1
NO 2 (Q23)

22f. From what other sources has the facility received payment for (this visit/these visits) and how much was paid by each source?
IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Patient or Family
Medicare
Medicaid
Private Insurance
VA
CHAMPVA/CHAMPUS
Other
Other Specify, Text

a. Patient or patient's family $_____.____
b. Medicare $_____.____
c. Medicaid $_____.____
d. Private Insurance $_____.____
e. VA $_____.____
f. CHAMPVA/CHAMPUS $_____.____
g. OTHER (SPECIFY:)
_____ $_____.____

23. ARE THERE ANY ADDITIONAL EVENTS FOR THIS PATIENT TO BE ACCOUNTED FOR?

Yes, No

YES ..... 1 (GO TO PATIENT ACCOUNTS SECTION (Q5a) OF NEXT EVENT FORM.)
NO ..... 2 (GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END.)